



## ALLIED HEALTHCARE APPLICATION

### INSTRUCTIONS

- A. Please type or print clearly. Answer ALL questions completely.
- B. If any question, or part thereof, does not apply, print "N/A" in the space provided.
- C. If more space is needed, continue on a separate sheet of your firm's letterhead, indicating question number.
- D. To this application, please attach copies of:
  - Marketing or advertising brochures
  - Descriptive materials provided to clients
  - Copy of JCAHO accreditation report, or other similar, if applicable
  - Other attachments as required in response to application questions
  - Most current annual financial statement prepared by a CPA
- E. All materials submitted or required shall be held in confidence.

### GENERAL INFORMATION

1. Insured \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street	City	State/Zip	County
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2. Tax Identification Number \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

3. Years in Business \_\_\_\_\_ Are you currently enrolled in a Patient Compensation Fund?  Yes  No

4. Mailing Address (if different than above)

Street	City	State/Zip	County
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5. List all locations and areas of operations (if more room is needed, please list on a separate piece of paper):

Street	City	State/Zip	County
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Street	City	State/Zip	County
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Street	City	State/Zip	County
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**6. LICENSING/CERTIFICATION**

Is applicant licensed to do business in the states listed above where required?  Yes  No

Has license ever been revoked, suspended, placed on probation or restricted in any way?  Yes  No

If Yes, please explain: \_\_\_\_\_

Are you certified by Medicare/Medicaid?  Yes  No

Do you bill Medicare/Medicaid?  Yes  No

If Yes, would you like someone to contact you regarding a quote for a surety bond?  Yes  No

**7. PATIENT/TREATMENT INFORMATION**

Fully describe the exact purpose of the operations, activities, services and professional procedures administered:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Provide names of all legal entities, including subsidiaries, desiring coverage. Please provide a description of the entity, percentage owned and date acquired. If applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date

9. Within the past five years, has applicant acquired, sold or discontinued any operations?  Yes  No

10. Is the applicant owned or operated by a hospital?  Yes  No

11. Applicant is:  Individual  Partnership  Corporation  Other \_\_\_\_\_

**REVENUE AND PAYROLL HISTORY**

	Revenue	Payroll
Last 12 months		
Estimated next 12 months		

**COVERAGE REQUESTED**

11. Requested Effective Date \_\_\_\_\_

(If new venture, please provide owner's resumé and description of related industry experience.)

12. \_\_\_\_ **Professional Liability**  Occurrence  Claims Made  Prior Acts Date \_\_\_\_\_

(Attach copy of prior claims made policy declarations if requesting prior acts.)

- \$100,000 per incident / \$300,000 aggregate
- \$500,000 per incident / \$500,000 aggregate
- \$1,000,000 per incident / \$1,000,000 aggregate
- \$1,000,000 per incident / \$3,000,000 aggregate
- \$2,000,000 per incident / \$4,000,000 aggregate
- \$3,000,000 per incident / \$3,000,000 aggregate

Other: \_\_\_\_\_

13.  **General Liability**  Occurrence  Claims Made  Prior Acts Date \_\_\_\_\_

(Attach copy of prior claims made policy declarations if requesting prior acts.)

Each Occurrence (cannot be excess PL limit) \$ \_\_\_\_\_

General Aggregate (other than products) \$ \_\_\_\_\_

14. Deductible

(Same deductible must be selected for both Professional and General Liability.)

none  \$1,000  \$5,000

\$10,000  \$25,000  Other \_\_\_\_\_

**EMPLOYEE BENEFITS LIABILITY** (General Liability Coverage must be selected)

15. Limits requested: \$100,000 per incident / \$300,000 aggregate

\$500,000 per incident / \$500,000 aggregate

\$500,000 per incident / \$1,000,000 aggregate

\$1,000,000 per incident / \$1,000,000 aggregate

Other: \_\_\_\_\_

**STOP GAP LIABILITY**

16. Stop Gap Liability (General Liability Coverage must be selected)

Each Person \$ \_\_\_\_\_

Each Disease \$ \_\_\_\_\_

Total Limit \$ \_\_\_\_\_

**COVERAGE HISTORY**

17. List Professional Liability policies covering the firm indicated in Question #1 over the past five years. If no insurance was in effect for a given year, state "None" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

18. List General Liability policies covering the firm indicated in Question #1 over the past five years. If no insurance was in effect for a given year, state "None" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

**CLAIM HISTORY**

19. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier?  Yes  No

If YES, please attach information for each claim, suit or incident that includes the following:

- Date of accident and date of notice
- Claimant name
- Amount paid or reserved
- Status – Open or Closed
- Insurance carrier
- Allegations
- Description of treatment rendered

20. Has any company cancelled, declined or refused to issue similar insurance?  Yes  No

If Yes, please explain:

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**SUPPLEMENTAL CLAIMS INFO**

Claimant \_\_\_\_\_ Status:  Open  Closed

Date of Loss \_\_\_\_\_ Date Reported \_\_\_\_\_

Expenses: Paid \_\_\_\_\_ Reserved \_\_\_\_\_

Indemnity: Paid \_\_\_\_\_ Reserved \_\_\_\_\_

Description of Loss:

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Claimant \_\_\_\_\_ Status:  Open  Closed

Date of Loss \_\_\_\_\_ Date Reported \_\_\_\_\_

Expenses: Paid \_\_\_\_\_ Reserved \_\_\_\_\_

Indemnity: Paid \_\_\_\_\_ Reserved \_\_\_\_\_

Description of Loss:

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**STAFFING ROSTER**

(Numbers below should reflect total annual hours and payroll for all employees/contractors.)

<b>Employees/Contracted Services</b>	<b>Est. Hours Worked Employees/Contractors</b>	<b>Est. Annual Payroll Employees/Contractors</b>
Physical therapists		
Nurses - Temporary Staffing		
Nurses - Other than Temporary Staffing		
Nurse aides/home health aides/homemakers		
Medical technicians		
Pharmacists		

Employees/Contracted Services	Est. Hours Worked Employees/Contractors	Est. Annual Payroll Employees/Contractors
Speech & hearing therapists		
Social workers		
Physician/physician assistant		
Nurse practitioner/clinic nurse specialist		
Live-in companions		
Occupational therapists		
Ultrasound/sonography Technicians		
Laboratory technicians		
X-Ray technicians		
Respiratory therapist		
All others (Describe – A breakdown of each type of staff and applicable hours should be provided.)		

**EMPLOYEES/INDEPENDENT CONTRACTORS**

21. Where are employees / independent contractors placed (by percentage)?

Private homes \_\_\_% Hospitals \_\_\_% Nursing homes \_\_\_% Assisted living \_\_\_%

Medical clinics \_\_\_% Doctor's offices \_\_\_% Other (describe) \_\_\_\_\_%

22. Does the applicant provide overnight beds or residential services?  Yes  No

23. Does the applicant provide treatment or services on their own premises?  Yes  No

24. What percentage of clients require:

Pediatric care \_\_\_% Cardiac care \_\_\_% Respiratory support \_\_\_% Infusion therapy \_\_\_%

25. Are any of your employees assigned to temporarily staff the:

If Yes, number of staff:

Emergency room  Yes  No \_\_\_\_\_

Labor & delivery rooms  Yes  No \_\_\_\_\_

Intensive care units  Yes  No \_\_\_\_\_

26. Please provide information requested for each medical director and/or physician providing services at the applicant's facility. (Attach copy of medical malpractice policy declarations.)

	Ins. Carrier and Effective Date	Policy Limits	State of Licensure	License Number	Employee or Contractor	Hours Per Month
Name - Medical Director						
Name - Physician						
Name - Physician						

**HIRING/SCREENING AND EMPLOYMENT PROCEDURES**

27. Are employees'/contractors' references contacted before hiring or placement?  Yes  No

Check all that apply: \_\_\_\_\_ Written \_\_\_\_\_ Verbal

28. Check all the following that apply if obtained, verified and filed as part of each employee screening and hiring process:

- |                       |       |                              |       |
|-----------------------|-------|------------------------------|-------|
| Applications          | _____ | Multi-state registry         | _____ |
| Drug/HIV/Hep. Testing | _____ | Criminal background vchecks  | _____ |
| Education/Competency  | _____ | Licenses/annual confirmation | _____ |

29. Does applicant question prospects about previous claims or suits?  Yes  No

30. Are employees required to actively participate in continuing education?  Yes  No

31. Does applicant verify any pending license suspensions, revocations or pending disciplinary actions?  Yes  No

32. Are professional employees required to carry their own insurance?  Yes  No

If Yes, what minimum is required? \$\_\_\_\_\_

Are certificates of insurance kept on file?  Yes  No

33. Do you subcontract work out to other agencies?  Yes  No

If Yes, please explain \_\_\_\_\_

**ACCREDITATION**

34. Is applicant a member of?

- |                              |       |                                   |       |
|------------------------------|-------|-----------------------------------|-------|
| JCAHO                        | _____ | National Association of Home Care | _____ |
| CHAP                         | _____ | National League for Nursing       | _____ |
| Nat'l Homecaring Council     | _____ | Nat'l Assoc. For Home Care        | _____ |
| Nat'l Assoc. of Private Duty | _____ | American League for Nursing       | _____ |
| Am. Public Health Assoc.     | _____ | Nat'l Hospice Organization        | _____ |
| Other                        | _____ |                                   |       |

35. Is applicant certified for Medicare/Medicaid reimbursement?  Yes  No

**RISK MANAGEMENT**

36. What management body oversees the quality of patient care?

(e.g., medical director, advisory board, etc.) \_\_\_\_\_

37. Do you have a formal written quality assurance and risk management program?  Yes  No

Person responsible: \_\_\_\_\_ Title: \_\_\_\_\_

38. Does applicant participate in any health fairs/health screening?  Yes  No

If Yes, what percentage of total revenue is from these services? \_\_\_\_\_

39. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain in an attachment any "No" answers:

- a. Physician notification in the event of changes in the patient's condition  Yes  No
- b. Communication to supervisors and team members  Yes  No
- c. Drug administration procedures  Yes  No
- d. Medical emergencies  Yes  No

- e. Daily work reports (nursing reports, hospital notes, etc.)  Yes  No
- f. Patient selection/physician home care treatment plan  Yes  No
- g. Service discontinuation  Yes  No
- h. Safe lifting, transferring and ambulating  Yes  No
- i. Incident reporting (medication errors, patient injury, etc.)  Yes  No
- j. Sexual/physical abuse awareness training  Yes  No
- k. Advance directives (living will)  Yes  No
- l. Medical equipment training  Yes  No
- m. Patient's rights  Yes  No
- n. Keep medical records on all patients  Yes  No

40. How are medical emergencies handled?

- a. On-call physicians?  Yes  No
- b. Affiliated physicians on premises?  Yes  No
- c. Hospital and/or emergency center?  Yes  No

If Yes, is hospital and/or emergency center located within a 15 minute drive under typical conditions?  
 Yes  No

d. Other (explain) \_\_\_\_\_

41. Specify arrangements for storage and dispensing of drugs: \_\_\_\_\_

42. Does applicant sponsor any sporting, fundraising or social events?  Yes  No

Please explain \_\_\_\_\_

43. Does the applicant provide any flu shots?  Yes  No

If Yes, what percentage of total revenue is from these services? \_\_\_\_\_

**CONTRACTUAL AGREEMENTS**

44. Does applicant enter into contractual agreements (e.g., hospitals, nursing homes)?  Yes  No

45. Do contractual agreements contain hold-harmless or indemnification clauses favorable to the applicant?  
 Yes  No

46. Is applicant required to name any other entity as an additional insured?  Yes  No

Please list name and address of each entity and the business relationship.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

**YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.**

**Applicant's Warranty Statement:** The undersigned represents to the best of his/her knowledge and belief the particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue or incomplete any statement made will immediately be reported in writing to the Company, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The signing of the application does not bind the undersigned to purchase the insurance, nor does the review of the application bind the Company to issue a policy. It is understood the Company is relying on the application in the event the policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued and may be attached to and become part of the policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

SIGNATURE OF APPLICANT \_\_\_\_\_ DATE \_\_\_\_\_

(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

Producer's Address: \_\_\_\_\_  
Street City State/Zip

Surplus Lines Agent \_\_\_\_\_ License # \_\_\_\_\_